The e-technology in the PCMH

Dr. Larry Fields

Past President, American Academy of Family Physicians

KENTUCKY ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR KENTUCKY

NCQA's Definition of PCMH

A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a personal physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience and optimal health throughout their lifetimes.

Think You're a PCMH Now?

Well …

- Does your practice include at least 4 of the following technology components?
  - Electronic Health Record System
  - e-Prescriptions
  - e-Appointment Scheduling
  - Disease/Population Management Software
  - Evidence-based Decision Support
  - Web-based Information Sharing with Patients
  - e-Visits
- Does your practice have a formal patient feedback process in place which evaluates the patient's experience/satisfaction?

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and patient communication**	**4**
B. Uses data to show it meets its standards for patient access and communication**	**5**
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	**6**
E. Uses data to identify important diagnoses and conditions in practice**	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	**7**
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	**4**
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	**3**
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	**3**
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

****Must Pass Elements**

PPC Scoring

- **9 standards = 100 points**
- **Three levels of recognition,** based on total points achieved
  - **Recognized—Level 1**
    - 25 – 49 points
  - **Recognized—Level 2**
    - 50 – 74 points
  - **Recognized—Level 3**
    - 75 – 100 points
  - **Not Recognized (or reported)**
    - 0 – 24 points

Standard 1: Access and Communication

- Does your practice provide patients with any alternatives to the traditional appointment like e-Visits or group visits?
- Do you have a practice Web portal that:
  - offers patient appointments online?
  - offers patients opportunities to interact with physicians and support staff?
  - does your portal recognize Health Literacy issues?

Standard 2: Patient Tracking and Registry Functions

- Does your Electronic Health Record or Disease Registry have capability for data mining? Create report on:
  - Patients with specific allergies / tobacco use / risk of falls
  - BP/WT/HT/BMI
  - Immunization/Screenings
  - ID patients with/without Advance directives
  - Ancillary Studies such as Lab/Radiology values
- Do appropriate staff have training and access to perform patient recalls and/or reporting?

Standard 3: Care Management

- Do you send preventive service clinical reminders to:
  - Patients?
  - Diabetic Educators?
  - Ancillary or other staff?
  - Subspecialists/Consultants?
- Does your EHR or Registry provide you with evidence-based clinical tools that are age and sex specific?
- Does your EHR or Registry provide patient friendly visual reports for patients on their disease progress? (i.e. diagrams of A1C levels)
- How are patients reports from Hospitals, Managed Care Agency integrated into your EHR/Registry? (e.g. Hospital Discharge Summaries)

Standard 4: Patient Self-Management Support

- Does your practice's Web portal contain a Health Risk Appraisal?
- Does your practice's Web portal contain links to self-management support programs?
- Does your electronic system support the Personal Health Record?

Standard 5: Electronic Prescribing

Is your e-Rx software

- ❑ Linked to patient specific demographic and clinical information?
- ❑ Capable of creating a secured Rx for controlled substances?
- ❑ Have capability to receive data back to acknowledge Rx was filled?
- ❑ Identifies drug-allergy / interactions?
- ❑ *Request Medication History?*

Standard 6: Test Tracking

Does your EHR / Registry:

- ❑ Track all labs, imaging, and ancillary tests?
- ❑ Flag abnormal results?
- ❑ F/U documentation on abnormal results?
- ❑ Interface with your practice Web portal to provide patient access to their test results?

Standard 7: Referral Tracking

"… electronic system to assist in tracking practitioner referrals designated as critical until the subspecialist or consultant report returns to the practice. The [electronic] system should track status of the reports.

Standard 8: Performance Reporting and Improvement

"The practice measures or receives data on the following types of performance by physician:

- Clinical procedures (e.g. % of women 50+ mamo)
- Clinical outcomes (e.g. HbA1c level for diabetics)
- Service data (e.g. backlogs or wait times)
- Patient safety issues (e.g. medication errors)

Standard 9: Advanced Electronic Communications

- Does your technology systems adhere to CCHIT standards?
- What data and security system policies & procedures are in place within your practice?
- What HIPAA compliance practices do you have in place in your practice?
- Availability of interactive Web site?

CMS's Medical Home Demonstration

- Tax Relief and Health Care Act of 2006 (sec. 204)
- Will operate in up to 8 states, including urban, rural, underserved areas
- 3 years
- Goal: "… to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations"

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What Is a Medical Home?

It's all about practice redesign. A medical home is a physician practice that meets certain standards pertaining to:

- Access
- Clinical information systems
- Continuity of care
- Coordination of care across providers and settings
- Decision support
- Delivery system design
- Patient/family engagement

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Two Tiers of Medical Homes

- Tier 1: Basic medical home services, basic care management fee
- Tier 2: Advanced medical home services, full care management fee

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Tier 1 Requirements

- 17 requirements in 9 domains, such as:
  - Written standards for patient access
  - Individualized plan of care
  - Electronic data system to identify/track patients
  - Use of evidence-based guidelines for diagnosis and treatment
  - Provision of patient education and support
  - Tracking of tests and referrals

Tier 2 Requirements

Tier 1 requirements *plus*

- Use of electronic health record to capture clinical information (e.g., blood pressure, lab results)
- Systematic approach to coordinate facility-based and outpatient care
- Review of post-hospitalization medication lists
- 3 of 9 additional capabilities (e.g., e-prescribing, performance measurement, electronic communication with patients and other providers)

What Is the Care Management Fee?

Per Member Per Month Payments			
Medical Home Tier	**Patients with HCC Score <1.6**	**Patients with HCC Score ≥1.6**	**Blended Rate**
1	$27.12	$80.25	$40.40
2	$35.48	$100.35	$51.70

- HCC score indicates disease burden and predicted future costs to Medicare
- Nationwide, 25% of beneficiaries have HCC ≥ 1.6, and are expected to have Medicare costs that are at least 60% higher than average

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Research Demonstrates the Value of the PCMH

Having a regular source of primary care is associated with:

- Lower emergency room utilization
- Fewer hospital admissions
- Fewer unnecessary tests and procedures
- Less illness and injury
- Lower per person costs
- Improved quality of care
- Higher patient satisfaction

TODAY'S CARE		MEDICAL HOME CARE
My patients are those who make appointments to see me	→	Our patients are those who are registered in our medical home
Patients' chief complaints or reasons for visit determines care	→	We systematically assess all our patients' health needs to plan care
Care is determined by today's problem and time available today	→	Care is determined by a proactive plan to meet patient needs without visits
Care varies by scheduled time and memory or skill of the doctor	→	Care is standardized according to evidence-based guidelines
Patients are responsible for coordinating their own care	→	A prepared team of professionals coordinates all patients' care
I know I deliver high quality care because I'm well trained	→	We measure our quality and make rapid changes to improve it
Acute care is delivered in the next available appointment and walk-ins	→	Acute care is delivered by open access and non-visit contacts
It's up to the patient to tell us what happened to them	→	We track tests & consultations, and follow-up after ED & hospital
Clinic operations center on meeting the doctor's needs	→	A multidisciplinary team works at the top of our licenses to serve patients